STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGOLAND CHRISTIAN VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000		F0000		

This visit was for a Post Survey Revisit (PSR) to the PSR completed on 4/20/11 to the Recertification and State Licensure Survey completed on 2/23/11.

This visit was in conjunction with a Post Survey Revisit (PSR) to Complaint IN00090528 investigated on 5/19/11.

Survey dates: June 14, 15, and 17, 2011

Facility number: 001198
Provider number: 155637
AIM number: 100471000

Survey team:
Regina Sanders, RN-TC
Marcia Mital, RN
(June 15, 2011)
Sheila Sizemore, RN
(June 15, 2011)
Kelly Sizemore, RN
(June 15 and 17, 2011)

Census bed type:
SNF: 26
SNF/NF: 106
Residential: 39
Total: 171

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census payor type: Medicare: 28 Medicaid: 76 Other: 67 Total: 171 Sample: 14 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2. Quality review completed on June 20, 2011 by Bev Faulkner, RN			
F0282 SS=E	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, record review, and interview, the facility failed to ensure physicians' orders and residents' plans of care were followed related to medication administration, skin tear interventions,and fall interventions for 5 of 14 residents reviewed for following residents' plans of care and physicians' orders in a total sample of 14 residents (Residents #B, #C, #D, #E, and #F) Findings include:	F0282	Event ID#OVPC13 6/27/11 F 0282 What is the corrective action taken for the resident found to be affected by the deficient practice? 1. Resident #C's MD was called 6/14/11 to clarify aricept order. The order was clarified to continue with Aricept 5 mg po qHS times four weeks and then increase dose to 10 mg po QHS for diagnosis of cognitive disorder.2. Resident #D's physician was notified 6/15/11 regarding condition of skin tear. Bactroban was discontinued and area open to air.3. Resident #B order for Bacitracin to right gluteal	06/27/2011

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	1. Resident #C's record was reviewed on 06/14/11 at 2:35 p.m. The resident's diagnosis included, but was not limited to, dementia. A Physician's order, dated 05/25/11, indicated an order for Aricept (cognition medication) 5 mg (milligrams) at bedtime for 30 days then increase the Aricept to 10 mg at bedtime. A Medication Administration Record (MAR), dated 05/11, indicated the resident received the Aricept 5 mg at bedtime on May 26-31, 2011. There was a lack of documentation on the MAR, dated 06/11, to indicate the resident had an order for Aricept 5 mg at bedtime. There was a lack of documentation on the MAR, dated 06/11, to indicate the resident received the Aricept as ordered by the physician. During an observation of the Aricept medication card on 06/14/11 at 3:20 p.m., with LPN #3 present, the medication card indicated it had been delivered by the pharmacy on 05/25/11 and 30 tablets of Aricept had been delivered. The Aricept medication card indicated there were 15 tablets left in the card. (there should have been 20 tablets used if given every night).		area was updated by physician 6/15/11 to discontinue Bacitractin to right gluteal area leave open to air. 4. Resident #E's physician was notified 6/17/11 and order was clarified to Voltaren apply 2 GM to each hand BID due to pain.5a. Resident F's care plan was updated 6/15/11 for resident to have nurse alarm in bed 5b. Resident #F a note written 6/17/11 in nurses notes that she is encouraged to wear geri sleeves and will wear for short period of time and remove. 6/20/11 note in nurses note states resident now refusing to have geri sleeves applied. Physician order 6/20/11 to discontinue geri sleeves.How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents have the potential to be affected by this deficient practice. Whole house audit was conducted on 6/17/11 of all resident records.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?The nurse management team will be trained on how to complete the end of month physician order, MAR, and TAR review process. Only trained personnel will be allowed to complete this monthly process. All licensed staff working the 11-7 shift will be educated on the nightly 24-hour physician order	

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	During an interview on 06/14/11 at 3:20 p.m., LPN #3 indicated the Aricept order was not on the MAR. She indicated the Aricept had not been given as ordered. 2. Resident #D's record was reviewed on 06/15/11 at 10:55 a.m. The resident's diagnosis included, but was not limited to, dementia. A Physician's order, 05/25/11, indicated an order for Bactroban (antimicrobial cream) to the resident's left shin wound daily until healed. The TAR (Treatment Administration Record), dated 05/11, indicated the Bactroban treatment had been completed daily on May 25-30, 2011. The TAR indicated the Bactroban treatment had not been completed on 05/31/11 due to the resident being out of the building. There was a lack of documentation on the TAR, dated 06/11, to indicate the resident had an order for the Bactroban treatment. There was a lack of documentation on the TAR, dated 06/11, to indicate the Bactroban treatment had been completed as ordered by the physician. There was a lack of documentation in the resident's Physician's Orders and the Nurses' Notes, dated 05/25/11 to 06/15/11,		chart review guideline process. This process includes verifying that all new physician orders from the previous 24 hours have been placed on the Medication Administration Records and on the Treatment Administration Records as indicated. All licensed staff will be educated on transfer order clarification and also the month end process that all new medication or treatment orders received after the Physician Order Sheets have been signed as reviewed through the end of month process have been transcribed to both the current month's MAR and/or TAR and the upcoming month's MAR and/or TAR. Nurse Managers will perform a double check of this each day during their clinical review process beginning on the 23rd of each month through the last day of the month to assure compliance. All resident care plans have been reviewed and updated per resident assessment. A process has been established to communicate resident care plan needs to the CNA's on a daily basis. Nursing staff will receive both directed education and facility provided education on following individualized resident care plans and physician orders. What corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of	

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	to indicate the resident's left shin wound had healed or that the Bactroban had been discontinued. During an observation of the resident's left shin wound with RN #4 on 06/15/11 at 12:50 p.m., the resident had a scabbed area on the left shin. The resident's wife was present during the observation and indicated the staff were no longer putting a treatment on the resident's shin. During an interview on 06/15/11 at 1:15 p.m., RN #6 indicated the wound was not healed. 3. Resident #B's record was reviewed on 06/15/11 at 10:55 a.m. The resident's diagnosis included, but was not limited to, anemia. A Physician's order, dated 05/17/11, indicated an order for Bacitracin (antibiotic ointment) daily to the resident's right gluteal (buttock) open area. The TAR, dated 05/11, indicated the Bacitracin treatment had been completed as ordered 05/17/11 through 05/24/11. The TAR indicated the Bacitracin treatment had been discontinued on 05/24/11. There was a lack of documentation in the		Nursing and Administrator will monitor compliance through random weekly audits including physician order and MAR/TAR comparison and care plan intervention implementation for 3 months and report findings to the QA committee. The facility's internal QA team has been provided a tool that will be updated with each change in a resident's plan of care to facilitate daily monitoring of care plan approach implementation. Daily rounds will be conducted utilizing this tool to assist with monitoring and continued compliance.	

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	physician's orders, dated 05/17/11 through 06/15/11, to indicate the physician had discontinued the Bacitracin treatment. The resident's TAR, dated 06/11, indicated the staff had completed the Bacitracin treatment on 06/01/11 through 06/14/11. During an interview on 06/15/11 at 11 a.m., RN #1 indicated she was unsure why the Bacitracin treatment had been discontinued on 05/24/11. During an interview on 06/15/11 at 11:10 a.m., LPN #2 indicated she was using the Bacitracin on the resident's right gluteal area. 4. Resident E's record was reviewed on 6/15/11 at 10:05 a.m. Resident E's diagnoses included, but were not limited to, congestive heart failure, osteoarthritis, and osteomyelitis. Resident E's hospital discharge orders, dated 5/4/11, indicated to continue Voltaren (a medication for arthritis) gel apply topically twice a day to bilateral hands. The resident's admission physician's orders, dated 5/4/11, indicated the Voltaren gel was to be applied to the resident's hands twice a day as needed for pain.			

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The MAR (Medication Administration Record), dated 5/11, indicated the Voltaren was to be applied as needed twice daily to the resident's hands and had not been administered at all for the month of May.

The resident's MAR, dated 6/11, indicated the Voltaren gel was administered twice a day on 6/1/11 at 6 a.m. and 6 p.m. The MAR then indicated "rewritten 6/1/11." The MAR then indicated the Voltaren was to be applied to the resident's hands as needed. This was also yellowed out as discontinued. There was a lack of any further documentation on the MAR or the resident's TAR (Treatment Administration Record) of the Voltaren being applied to the resident's hands.

During an interview on 6/15/11 at 12:55 p.m., RN #1 indicated the hospital discharge orders should have been followed. She indicated the hospital orders take precedence and the nurse goes through the orders with the resident's physician. She indicated the Voltaren should have been applied twice a day. She indicated she did not know why the order had been discontinued on the MAR for June.

5. Resident F's record was reviewed on 6/15/11 at 10:09 a.m. Resident F's

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	diagnoses included, but were not limited to, senile dementia, anxiety, and stroke. A quarterly MDS (Minimum Data Set) assessment,dated 05/03/11, indicated Resident F was moderately impaired in decision making. The quarterly MDS assessment indicated Resident F required extensive assistance of one staff for transfers. A) A "Fall Risk" assessment, dated 5/30/11, indicated the resident was a high risk for falls, scoring 16, a score of 10 or higher places the resident at risk for falls. A care plan for falls, dated 2/14/11, lacked documentation of a fall intervention for a bed alarm. The fall intervention added on 5/30/11 indicated "Re-educate staff on proper use of bed alarm." A "Fall Management Program Note," dated 5/30/11, indicated "Resident was observed sitting on her room (sic) floor near doorway @ (at) 9:15 a.m. Per staff interview resident had been assisted to bed 15 min (minutes) prior. She had a low bed et (and) is believed to have crawled out as she stated 'just wanted to get out.' Resident has no injury. She was assisted to w/c (wheelchair). We will re-educate staff on proper use of alarm....Plan of action to prevent			

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	reoccurrence: Re-educate staff on proper use of bed alarm" An observation on 6/15/11 at 9:50 a.m., indicated Resident F had a bed alarm on her bed. During an interview on 6/15/11 at 10:58 a.m., RN #4 indicated "According to the report the resident did not have the alarm turned on." RN #4 indicated the CNAs are supposed to check the alarms to make sure the alarms are working. B) Resident F was observed on 6/15/11 at 9:50 a.m. and 10:20 a.m., the resident was up in her wheelchair and did not have on her geri sleeves. A physician's telephone order, dated 6/9/11 at 9:00 p.m., indicated "Monitor abrasion on R (right) upper (arrow pointing upwards) arm every shift until healed. Geri sleeves as tolerated d/t (due to) fragile skin." During an interview on 6/15/11 at 10:20 a.m., CNA #5 indicated the resident should have had on her geri sleeves. CNA #5 was observed on 6/15/11, applying Resident F's geri sleeves at 10:25 a.m. Resident F allowed the CNA to apply the geri sleeves without problem.			

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	This deficiency was cited on 02/23/11, 04/20/11, and 05/19/11. The facility failed to implement a systemic plan of correction to prevent recurrence. 3.1-35(g)(2)			

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F0323 SS=D	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F0323	Event ID#OVPC13 6/27/11 F 323 Chicagoland Christian Village continues to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accident. What is the corrective action taken for the resident found to be affected by the deficient practice? Resident F's fall care plan has been reviewed for accuracy and was updated 6/15/11 for resident to have an alarm in bed. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All residents assessed as being at risk for falls have the potential to be affected by this deficient practice. Whole house audit was conducted on 6/17/11 of all resident records.What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?All resident fall care plans and CNA care guide have been reviewed and updated per resident assessment. A process has been established to communicate resident care plan needs and changes to the CNA's on a daily basis. Nursing staff will	06/28/2011

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	Based on observation, record review and interview, the facility failed to ensure fall interventions were in place and working to prevent further falls from occurring for 1 of 6 residents with falls in a sample of 14. (Resident F) Findings include: An observation on 6/15/11 at 9:50 a.m., indicated Resident F had a bed alarm on her bed.		receive both directed education and facility provided education on following individualized resident care plans and physician orders. What corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of Nursing and Administrator will monitor compliance through random weekly audits including care plan intervention implementation for 3 months and report findings to the QA committee. The facility's internal QA team has been provided a tool that will be updated with each change in a resident's plan of care to facilitate daily monitoring of care plan approach implementation. Daily rounds will be conducted utilizing this tool to assist with monitoring and continued compliance.	

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	Resident F's record was reviewed on 6/15/11 at 10:09 a.m. Resident F's diagnoses included, but were not limited to, senile dementia, anxiety, and stroke. A quarterly MDS (Minimum Data Set) assessment, dated 05/03/11, indicated Resident F was moderately impaired in decision making. The quarterly MDS assessment indicated Resident F required extensive assistance of one staff for transfers. A "Fall Risk" assessment, dated 5/30/11, indicated the resident was a high risk for falls, scoring 16, a score of 10 or higher places the resident at risk for falls. A care plan for falls, dated 2/14/11, lacked documentation of a fall intervention for a bed alarm. The fall intervention added on 5/30/11 indicated "Re-educate staff on proper use of bed alarm." A "Fall Management Program Note," dated 5/30/11, indicated "Resident was observed sitting on her room (sic) floor near doorway @ (at) 9:15 a.m. Per staff interview resident had been assisted to bed 15 min (minutes) prior. She had a low bed et (and) is believed to have crawled out as she stated 'just wanted to get out.' Resident has no injury. She was assisted to w/c (wheelchair). We will			

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	re-educate staff on proper use of alarm....Plan of action to prevent reoccurrence: Re-educate staff on proper use of bed alarm" An undated CNA Care Record, indicated bed alarm was not marked. An undated C-hall report sheet, indicated a lack of documentation of a bed alarm for the resident. During an interview on 6/15/11 at 10:58 a.m., RN #4 indicated "According to the report, the resident did not have the alarm turned on." RN #4 indicated the CNAs are supposed to check the alarms to make sure the alarms are working. RN #4 indicated the bed alarm should have been checked on the CNA Care Record. A facility policy, dated 4/3/10 and titled "Fall Prevention" indicated "It is the policy of Christian Homes, Inc. to provide each resident with an appropriate assessment and interventions to prevent falls and to minimize complications if a fall occurs...." This deficiency was cited on 02/23/11 and 04/20/11. The facility failed to implement a systemic plan of correction to prevent recurrence.			

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	3.1-45(a)(2)			
F0328 SS=D	The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.			
	Based on record review and interview, the facility failed to ensure dressing changes, injection cap changes and measurements were completed weekly on a PICC (Peripherally Inserted Central Catheter) line for 1 of 2 resident's with PICC lines in a sample of 14. (Resident E) Findings include: Resident E's record was reviewed on 6/15/11 at 10:05 a.m. Resident E's diagnoses included, but were not limited to, congestive heart failure, osteoarthritis, and osteomyelitis.	F0328	Event ID#OVPC13 6/27/11 F 328 Chicagoland Christian Village continues to ensure that resident' s receive proper treatment and care for the following special serves:…Parental and enteral fluids… What is the corrective action taken for the resident found to be affected by the deficient practice? Resident E's PICC line was discontinued on 6/5/11, medications were continued as	06/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155637	A. BUILDING 00 B. WING	06/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHICAGOLAND CHRISTIAN VILLAGE	6685 E 117TH AVE CROWN POINT, IN46307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	A nurses' note, dated 5/12/11 at 6 a.m., indicated "Resident given ABT (antibiotic) IV (intravenous) Zosyn to R (right) PICC infused S (without) difficulty...drsg (dressing) D/I (dry and intact)..." A TAR (Treatment Administration Record), dated 1/01, (RN #1 indicated should have been dated 5/11, on 6/15/11 at 12:25 p.m.), indicated the PICC line dressing change, injection cap change, and the external length of the PICC line were to be done every 7 days and as needed. The TAR indicated the dressing change, injection cap, and measurement were completed on 5/12/11. There was a lack of documentation to indicate the dressing change, injection cap change, and measurement had been completed after 5/12/11. The TAR, dated 6/11, lacked documentation to indicate the PICC line dressing changes or the measurements of the external PICC weekly. The nurses' notes, dated 5/13/11 through 6/4/11, lacked documentation of the PICC line dressing and injection cap being changed, or of measurements of the external length of the PICC line.		ordered through a peripheral line. How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action will be taken? All current residents with PICC lines have the potential to be affected by this deficient practice. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur?All resident with PICC lines with have their medical records reviewed. All deficient practice identified will be immediately corrected. Each PICC line will receive a documented dressing change each week which includes injection cap changing and external length PICC line measurement. Nurse Management has received directed education regarding weekly PICC line documentation compliance. What corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? Director of Nursing and Administrator will review weekly PICC line documentation for compliance ongoing. Director of Nursing and Administrator will monitor compliance through random weekly audits including review of PICC line dressing documentation for 3 months and	

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	A nurses' note, dated 6/5/11 at 8 a.m., indicated "Called to room by CNA, entire PICC line laying in bed beside res(resident). Complete PICC line intact & measures 43 cm (centimeters). Site to R upper arm where PICC line removed is s (without) any bleeding, no signs of trauma or infection..." This was 24 days after the dressing had last been changed. During an interview on 6/15/11 at 12:25 p.m., RN #1 indicated the dressing and injection cap had not been changed nor had the external PICC line been measured weekly. An undated facility policy, titled "PICC Line or Medline Catheter Dressing Change", received from the Administrator via e-mail, on 6/15/11 at 7:57 p.m., indicated "...Frequency...After the first 24 hours the frequency is every seven days and PRN (as needed)...Inspect the exit site for swelling, redness, exudates. During all dressing changes assess the external length of the catheter to determine if migration (movement) of the catheter has occurred. Periodically confirm catheter placement, tip location, patency, and security of dressing...Using friction clean the catheter exit site with alcohol swabstick starting at the exit site...change the injection cap...when the dressing is changed...Apply transparent dressing..."		report findings to the QA committee.	

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R0000	3.1-47(a)(2)	R0000		